WORRIED SICK.

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SECONDARY TRAUMATIC STRESS AND BURNOUT

History

The diagnosis of PTSD was first codified in 1980 with DSMIII. Soon after, the literature began describing a secondary trauma that occurred among caregivers taking care of traumatized victims. One of the first books was about emergency services workers - Disaster Work and Mental Health, Hartsough and Myers (1985).

Among therapists, the most common conceptualization of this phenomena was labeled "countertransference." Among mental health care givers, the common term was "burnout." The phrase "compassion fatigue" was first used by Figley in 1991. The terms "secondary traumatic stress" and "vicarious traumatization" appeared around 1995.

A Lexicon for the "Stressed Out"

Burnout - a gradual defensive response to prolonged occupational exposure to demanding interpersonal situations.
Compassion fatigue - a specific kind of secondary traumatic stress. Sudden and acute, with PTSD-like symptoms, some believe it is a natural consequence of working empathically with traumatized clients.
Compassion strain
Compassion stress
Countertransference - from psychodyamic theory, an emotional reaction to the client by the therapist, which reflects a distortion resulting from the therapist's life experiences and associated with his unconscious, neurotic reactions to the client's transference. Examples include seeing oneself in the client, over-identifying with the client, or meeting one's needs through the client.
Co-victimization
Emotional contagion
Indirect trauma
Savior syndrome
Secondary survivor
Secondary traumatic stress - the sudden appearance of PTSD like symptoms in a caregiver, most likely tied to the client's traumatic experience.
Secondary victimization
Vicarious traumatization - a more specific kind of secondary traumatic stress, primarily of therapists of incest and sexual assault survivors. It is described as a permanent transformation in the inner experience of the therapist that comes about as a result of empathic engagement with the client's trauma material. The main symptoms are disturbances in the therapist's cognitive frame of reference - identity, world view, spirituality, beliefs, trust, safety, control, esteem, intimacy. Legal professionals working with family law, domestic violence and homicide are at risk. Attorneys may be more vulnerable than mental health professionals.

SECONDARY TRAUMATIC STRESS

Unlike burnout, STS is a sudden adverse experience by people who have close contact with a trauma survivor. Some regard it as a natural response to having empathy with such clients.

The symptoms are almost identical to PTSD - 3 content domains:

1) avoidance and numbing
2) re-experiencing
3) persistent arousal.

There is little empirical data about compassion fatigue. It may be experienced by 27% of emergency care workers. Like PTSD, this happens to a minority of those exposed -e.g. 20% of World Trade Center NYC residents developed PTSD, ~ 2% of NYC treaters developed STS.

Vulnerability:
extent of exposure
seeing traumatized children
dealing with body parts
prior history of trauma or mental disorder in the caregiver
lack of institutional support
strong empathy (?)
burnout in the caregiver

Institutional Prevention of Secondary Traumatic Stress
Problematic assumptions in a hierarchical system:
1) some people are more important than others
2) some people cannot be expected to spend much time responding to others
3) some people are more replaceable than others.

Ochberg (1991): 3 principles that underlie effective post-traumatic therapy applied to institutions:
1) Individuality - the institution must respect each member's unique needs and approach to recovery.
2) Normality - everyone is unique, but there is a general pattern of adjustment - what is happening is normal.
3) Empowerment - the trauma survivor needs to be included in the recovery plan so dignity and control can be recovered also.

Social support:
1) resources - better management of caseloads, increased staff time, adequate leave time, insurance that covers mental health care, adequate supervision.
2) help by clarifying what is going on and listening to what happened and how the worker feels
3) correct distortions
4) reframe the trauma
5) be empathetically tuned

Organizations should anticipate secondary traumatic stress:
1) They should develop plans for dealing with it
2) They should educate staff members
3) There should be a general program of prevention - group meetings, debriefings, involvement of the leaders, etc.
4) The program's effectiveness should be evaluated

BURNOUT

The term "burnout" was first used by Fruedenberger in 1974. It appeared in the occupational stress literature as a condition of people who work in human services and mental health. The first conceptualizations involved interpersonal relationships between caregiver and recipient. In the late 80's and 90's, a more industrial/organizational focus was developed and the organization itself was put under scrutiny.

The only European country where burnout levels have been reported as high as in the USA is in Poland where working standards are relatively poor. In 62 samples of 25,000 American employees, 20% were judged to be in the most advanced burnout phase. (Burnout may be higher in Japan and Asia.)

Burnout tends to reflect work load and institutional stress, rather than trauma. It is a gradual process where people feel overwhelmed and unable to effect change. It is seen in workers who have increased paperwork, decreased staff, decreased support, and increased workloads.

Burnout can lead to apathetic detachment, cynicism, or rigidity. The worker may feel overly involved emotionally, overextended, and overwhelmed. Interpersonal withdrawal can result in poor service delivery and depersonalization of clients. It has been associated with various forms of job withdrawal - absenteeism, intention to leave the job, lower productivity, less effectiveness, decreased job satisfaction, reduced commitment. People with burnout will have a negative impact on their colleagues. Burnout can be contagious. It may effect home-life. Health consequences are the same for any prolonged stress.

It is different than depression because it is specific to the work environment. But individuals who are more depression prone are also more vulnerable to burnout.

Defining and measuring burnout

Kahill (1988) identified 5 categories of symptoms:

1) physical symptoms (fatigue and physical depletion/exhaustion, sleep difficulties, somatic problems headache, GI, colds, flu.)
2) emotional symptoms (irritability, anxiety, depression, guilt, sense of helplessness)
3) behavioral symptoms (aggression, callousness, pessimism, defensiveness, cynicism, substance abuse)
4) work related symptoms (quitting the job, poor work performance, absenteeism, tardiness, misuse of work breaks, theft)
5) interpersonal symptoms (perfunctory communication with, inability to focus/concentrate on, withdrawal from clients/ coworkers, then dehumanizing/ intellectualizing clients)

The Maslach Burnout Inventory (MBI) is the best validated measure of burnout. There are 3 subscales:

1) emotional exhaustion - emotional exhaustion and over-extension due to work demands, most widely reported and most thoroughly analyzed. It prompts the action to distance oneself.
2) depersonalization - impersonal, unfeeling responses toward care or service recipients, cynicism, an attempt to put distance
3) lack of personal accomplishment - lack of positive feelings of competence in helping people and successful achievement - often the result of exhaustion and depersonalization. People may actually become less effective. It is not only caused by, it feeds back to the other two subscales.

Causes of burnout

Job/situational characteristics:

- Overload
- Role conflict - conflicting demands
- Role ambiguity - lack of information
- Severity of clients' problems
- Lack of support from supervisors - more important than support from coworkers
- Lack of feedback
- Lack of control
- Lack of autonomy - weaker link
- Lack of reciprocal loyalty
- Therapists who work in institutions rather than private practice

Occupational characteristics - emotional work requirements are more important than the above (e.g. a requirement to display or suppress emotions on the job, requirements to be emotionally empathic, etc)

Personal characteristics (these aren't as important as the social and situational factors)

- Younger than 30-40 - more a risk earlier in your career, although watch out for survival bias
- Gender neutral
- Unmarried
- Higher education?
- Low level of hardiness (involvement in daily activities, sense of control, openness to change)
- External locus of control (attributing events and achievements to powerful others or chance)
- Passive defensive coping style
- Neuroticism (anxiety, hostility, depression, self-consciousness, vulnerability)
- Type-A behavior (competition, time pressured lifestyle, need for control)
- "Feeling" types

Burnout may arise from chronic mismatches between people and their work setting in these six areas:

1) Workload - excessive or the wrong kind - person is not trained for it, or don't like it. Emotional work that requires people to display emotions inconsistent with their feelings. This is all related mostly to exhaustion.
2) Control - related to inefficacy and reduced personal accomplishment. They may have insufficient control over resources or insufficient authority. Too much responsibility may be a problem, especially if there is not corresponding authority. Helpless responsibility.
3) Reward - insufficient financial rewards or lack of appreciation, lack of pride in doing something important or well. Leads to inefficacy.
4) Community - lack of positive connection with others in the workplace. People like to share praise, comfort, happiness, humor with people they like and respect. This reflects a shared sense of values. Most destructive is chronic and unresolved conflict.
5) Fairness - Fairness communicates respect and confirms people's self-worth. Unfair treatment is frustrating and exhausting and fuels a sense of cynicism.
6) Values - The job may be unethical, or not in line with career aspirations. There may be a discrepancy between the lofty goals of the organization and the actual practice (high quality service versus cost containment).

Engagement vs. burnout

Engagement is the opposite of burnout. Work is important, meaningful, and challenging. Engagement is comprised of energy, involvement, and efficacy. It is different than organizational commitment, which is about allegiance to the organization, not a focus on the work. The six areas of job fit are mostly positive. There is vigor, enthusiasm, and absorption. Burnout seems mostly related to job demands. Engagement mostly related to availability of job resources (control, feedback, learning opportunities.)

Compassion Satisfaction
What prevents people from developing PTSD when they are exposed to trauma? King (1998) hardiness (control /competence, commitment, seeing change as challenge), and social support.

What sustains a person who is dealing with these levels of trauma? We are glad we can help. There are payments for caring also - feeling connected.

Individual focused interventions for burnout
Most discussions of burnout intervention focus on individual centered solutions like strengthening internal resources, getting another job, changing work behavior, etc. This is ironic since situational and organizational factors play a bigger role in burnout than individual factors. Research shows that people can learn new coping skills, but it has not been shown that they can apply it at work. Roles at work require that people behave in specified ways with specified people. And when new coping strategies are applied at work, the evidence is mixed that it prevents burnout. Individual intervention strategies include:

- Stress inoculation training
- Relaxation
- Time management
- Assertiveness training
- Rational emotive therapy
- Social skills
- Team building
- Meditation

In some cases individual interventions can lead to a reduction in exhaustion, but in other cases it has not. In general there is no improvement in cynicism or inefficacy.

Organizational focused interventions for burnout
Findings from the literature indicate that the focus of change needs to be the job environment as well as the person in it. Managerial practice needs to change along with educational interventions as described above. Concentration on the 6 areas of mismatch is important. Some overload can be coped with if there is an increase in reward, for instance. Combining the managerial and educational approaches to intervention builds engagement with work. A work setting that is designed to support the positive development of energy, vigor, involvement, dedication, absorption, and effectiveness among employees should be successful in promoting well-being and productivity. Building engagement, not just reducing burnout needs to be the goal.

THE POWER OF NEGATIVE THINKING
American culture has been saturated by an optimistic bias which has been present since the American Revolution.

Benjamin Franklin's Poor Richard's Almanac:
"Hope of gain lessens pain."

"He that's content has enough; he that complains has too much."
"Let thy discontents be secrets; - if the world knows them 'twill despise thee and increase them."

American self-help books, along with seminars, CD's, personal coaching is a $2.5 billion/year industry.

Smiley Face - probably originated in 1963 from a graphic artist Harvey Ball. He was hired to boost moral for the State Mutual Insurance Company in Worcester, MA. It was later turned into a fad by Bernard and Murray Spain in 1970 in Philadelphia.

The positive psychology movement - let's focus on what's right with people (Martin Seligman PhD 1990's.)

Solution-focused therapy (1996) - no more problem talk in therapy - just solutions. Based on a post-modern view that we are free to become who we want at any given moment. Change the narrative construction of your life and you will be transformed to the better.

Complaining

Complaining is so ubiquitous it is difficult to study. People complain all the time, about everything. Why? What does it accomplish?

Dissatisfaction - We may complain when the world does not meet our expectations. We can have both a dissatisfaction threshold and a complaining threshold.

People may complain to accomplish a goal
- allows people to vent
- people feel better after complaining sometimes
- may prevent rumination
- stifling emotions may be related to health problems
- conveys information about the person complaining - what their standards are
- saves face in some situations
- may diffuse negative emotional experiences
- help with insight
- express solidarity
- socialize

However, complaining has negative consequences
- people find it annoying
- it affects how they are perceived by others (chronic complainers.)
- it may make them more dissatisfied
- it makes others more dissatisfied - mood contagion - create dissatisfaction an conflict.

Complaining and Physical Health

Watson, Pennebraker (1989): People high in negative affect (anger, disgust, scorn, guilt, fearfulness, depression, focus on the negative) are no less healthy and do not have a higher mortality than positive people when measured by objective standards. They just complain a lot.

Defensive Pessimism, Strategic Optimism, and Performance

There is clear evidence that positive attitudes can help with some outcomes such as coping and satisfaction, but is it better all the time for everyone?

Defensive pessimism: a strategy that anxious individuals may use by setting unrealistically low expectations and then devoting considerable energy to rehearsing or reflecting on all possible outcomes they can imagine in a situation. Defensive pessimism is different than dispositional pessimism, which can have debilitating motivational effects. Defensive pessimists are anxious and this is a way to help them cope. They do better when compared to anxious individual who do not use defensive pessimism.

Strategic optimism: individuals set optimistic expectations for their own performance and actively avoid extensive reflection.

Research shows that these two groups perform equally well and tasks and both groups show performance decrements when they are not allowed to use their preferred strategies. The optimists tend to be in a better mood and more satisfied with the same performance. You can cheer up the pessimists, but positive mood impairs their performance and does not improve their satisfaction. Feeling good is not always the highest priority.

In the elderly, a realistically pessimistic perspective is associated with better adaptation to life events

Optimism can derail us. One study shows that optimists remembered feedback less well and thought they had less need to improve their performance than they actually did (Norem 2001a). In post coronary artery disease patients, those who were unrealistically optimistic showed the largest decrease in exercise over time (Davidson and Prkachin 1997).

TURN THAT FROWN UPSIDE DOWN OR ELSE!

Many workplaces expect employees to have positive attitudes and affect.

Can the pressure to be happy contribute to unhappiness? Can people feel guilty if they don't feel good?

We are less able to accept feeling bad if we interpret feeling bad as being sick or immoral. Furthermore, there is little empirical reason to suspect and no empirical evidence that people can change their outlook. We can't cure pessimism. Positive and negative affects are probably genetically influenced. They won't be influenced by positive or negative thinking. And there are costs to pretending to oneself and others that one is happy when one is not.

Being Not OK Might Be Just Fine

What we typically view as negative and dysfunctional can be functional. By imposing a standard that everyone should be optimistic, and that complaining is dysfunctional, we may be harming people rather than helping them.

The fundamental question is what the person doing helping him adapt and maintain a task focus.

Dweck (1988) studied how children coped with failure on learning tasks. What was most important for success was not their emotional expression, but whether they were task focused or outcome focused. The children who were task focused persisted and sought new solutions. They were interested in how to learn. They did not regard failure as an indication that they were stupid and inept. The outcome focused children

tended to give up prematurely. Their cognitions tended to be focused more upon themselves than the task, and they engaged in various defensive maneuvers such as bragging, discounting, etc. They were concerned that their performance reflected who they were - I'm stupid, incompetent.

Defensive pessimism does promote task focus for some individuals, and complaining may help some individuals maintain a task focus.

We need to tolerate and appropriately express negative feelings in ourselves and others. No one likes a whiner, but even the most hopeless optimist can benefit from the pessimist's keen sense of reality.

EMPATHY, ENMESHMENT, COMPASSION, AND EQUANIMITY: A BRIEF REFLECTION

In the Eastern spiritual traditions, four positive emotions are described as the 'brahma-viharas", or the heavenly abodes:

Lovingkindness (metta) Unlike passion which is enmeshed and complicated by desire; or sentimentality which is full of denial and wishful thinking, metta is best described as a warm friendliness toward ourselves and others that is not dependent on getting something in return. It is free of greed and anger.

Compassion (karuna) When we turn lovingkindness toward suffering, either in ourselves or others, we experience compassion. Unlike pity which separates us from the person who is suffering, compassion connects us. We can do this while feeling strong and courageous without being overwhelmed by the other's suffering.

Sympathetic joy (mudita) When we turn our lovingkindness toward someone's happiness, we experience sympathetic joy. It is a rare and beautiful feeling to truly take joy in someone else's happiness. This is the most difficult of the brahma-viharas.

Equanimity/Balance (upekkha) True equanimity is not apathy or indifference, which separates us from other people. Rather equanimity is a spacious stillness in the recognition of how things are right now in this moment. It doesn't mean that we like it, or approve of it. It means that we can face the truth of what is happening.

Figley states the problem of secondary traumatic stress, and burnout to a certain extent, is that being empathetic with people who are suffering takes a toll on the caregiver, and some sort of emotional damage is inevitable.

It may be that the problem is not our empathy, but rather our attachment to controlling a certain outcome. Very few things are totally in our control. Our best defense against STS and burnout is not the curbing of our compassion, but in cultivating a sense of equanimity in our work and in our lives.

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